Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AUSTIN PAIN ASSOCIATES
2501 W. WILLIAM CANNON DR
SUITE 401
AUSTIN, TX 78745

Respondent Name

Houston General Insurance Co

Carrier's Austin Representative Box

Box Number 11

MFDR Tracking Number

M4-11-2595-01

MFDR Date Received

March 31, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated March 31, 2011: "…No modifier required …"

Amount in Dispute: $721.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response from carrier. Reciept of the medical fee dispute was acknowledged by the carrier on April 6, 2011.

Response Required by: Houston General Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 19, 2010	Laboratory	$721.92	$300.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, sets out the procedures for resolving medical fee disputes filed prior to June 1, 2012
2. 28 Texas Administrative Code §134.203 sets out billing requirements for professional medical services
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 20, 2010

- 4 Required Modifier Missing or inconsistent w/prIced

- 91 Repeat Clinical Diagnostic Laboratory Test
- RP3 CMS statutory exclusion/svc not paid to physicians

Explanation of benefits dated November 12, 2010
- 193 Original payment decision maintained
- 4 Required modifier missing or inconsistent w/priced
- Repeat Clinical Diagnostic Laboratory Test

Issues

1. What modifiers are required for the services in dispute?
2. Is reimbursement due?

Findings

1. The workers' compensation carrier (Houston General Insurance Co) denied all services using claim adjustment code "4" which states that "Required modifier missing or inconsistent w/prced", and furthermore denied services with "91 Repeat Clinical Diagnostic Laboratory Test." Texas Administrative Code 134.203(b)(1) states, in pertinent part, …"for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   (1) Medicare payment policies, including its coding; billing;…"
   The medical bill indicates that the requestor billed code 80299 with the 91 modifier, and all other codes with no modifier.The applicable medicare policy for billing may be found in the Medicare Claims Processing Manual, Chapter 16 – Laboratory Services at http://www.cms.gov. Section 100.5.1 indicates that modifier -91 may be used to indicate that a test was performed more than once on the same day for the same patient for the purpose of obtaining multiple results in the course of treatment. Documentation supports that: (1) multiple tests were conducted for code 80299; and that (2) codes 83925, 92520, 82145, 82205, 80154, 83840, 83992, 82055, 82540 tests were performed once. The division concludes that the 91 modifier was appended in accordance with CMS policies, and that no modifiers were required for the remaining disputed services. The respondent's denial of payment is not supported.

2. For the reasons stated above, the services in dispute are eligible for payment pursuant to 28 TAC §134.203(e) which states:
   "The MAR for pathology and laboratory services not addressed in subsection (c) (1) of this section or in other Division rules shall be determined as follows:
   (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and
   (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."
   CMS payment policy files identify those clinical laboratory codes which contain a professional component, and those which are considered technical only. The codes in dispute are not identified by CMS as having a possible professional component, for that reason, the MAR is determined solely pursuant to 28 TAC §134.203(e)(1). The maximum allowable reimbursement(MAR) for the services in dispute is 125% of the fee listed for the codes in the 2010 Clinical Diagnostic Laboratory Fee Schedule found on the Centers for Medicare and Medicaid Services website at http://www.cms.gov. There are no CCI conflicts, Medicare billing exclusions, that apply to the clinical laboratory services in dispute; therefore, the total MAR can be calculated as follows:

Code	Description	MAR Calculation	MAR
80299	Quan Drug Nes	$19.61 x1.25	$24.51
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83925	Opiates(s) drug and metabolites each	$27.87 x1.25	$34.84

82520	Cocaine abolite	$21.70 x1.25	$27.13
82145	Amphetamine/methamphetamine	$22.27 x1.25	$27.84
82205	Barbiturates Nes	$16.41 x1.25	$20.51
80154	Benzodiazepines	$26.49 x1.25	$33.11
83840	Mehtadone	$23.39 x1.25	$29.24
83992	Phencyclidine	$21.05 x1.25	$26.31
82055	Alcohol, any spec xcpt brth	$15.47 x1.25	$19.34
82540	Creatine	$6.64 x1.25	$ 8.30
		TOTAL MAR	$300.15

The total allowable for the disputed charges is $300.15. The carrier paid 0.00, therefore reimbursement in the amount of $300.15 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $300.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.